Supreme Court, U.S.
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No. _____

IN THE
SUPREME COURT OF THE UNITED STATES

ADVOCACY ORGANIZATION FOR
PATIENTS AND PROVIDERS,
a non-profit Michigan corporation, et al.,
Petitioners,

v.

AUTO CLUB INSURANCE ASSOCIATION, et al.,
Respondents.

On Petition For Writ Of Certiorari
To The United States Court of Appeals
For The Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Did the Lower Court err in affirming the District Court's ruling which dismissed petitioners' allegations that respondents violated RICO where respondent insurance companies represented to petitioners that they would pay all reasonable charges for medical treatment of insured auto accident victims, as required by state no-fault law, when subsequently, respondent insurance companies, acting in concert, and by utilizing and controlling respondent review companies, refused to fully reimburse such medical expenses, and threatened petitioners, as providers, with legal action if they sought to recover unpaid balances from insured patients?

PARTIES TO PROCEEDING

Petitioners

Advocacy Organization for Patients and Providers, a non-profit Michigan corporation; Gordon Allen, P.T.; Bradley Bengston, M.D.; Richard A. Bereza, M.D.; John Bruder, M.D.; Edward Brophy, D.O.; Ronald Clark, M.D.; A. George Dass, M.D.; Don Davis, M.D.; Michael Dorsey, M.D.; Michael Fitzsimmons, M.D.; Fred M. Hankin, M.D.; Thomas Haverbush, M.D.; Bruce Henderson, M.D.; John Hogikyan, M.D.; Chester R. Hoyt, M.D.; Gerald Jerry, Jr., M.D.; Paul Kenyon, M.D.; Bert J. Korhonen, M.D.; Robert Kreitsch, M.D.; Andrea Kuldanek, M.D.; Norman Licht, M.D.; David Lint, M.D.; Barry McAlpine, D.C.; Joseph McGraw, M.D.; Kenneth Merriman, M.D.; David Michael, D.O.; Stephen Montes, D.O.; W. David Moore, M.D.; Edward J. Nebel, M.D.; Raymond Noellert, M.D.; Larry Pack, M.D.; Alan Plona, M.D.; Vincent R. Prusick, M.D.; Steven Ringler, M.D.; Paul E. Roose, D.O.; Peter Rosenbaum, M.D.; Diana Rothman, M.D.; Mark Russell, D.O.; Phillip Sorensen, M.D.; Kenneth Stephens, D.O.; David Swastek, M.D.; James Trefler, M.D.; Gregory M. Uitvlught, M.D.; David A. VanderWall, M.D.; Norman Walter, M.D.; Edward Washabaugh, M.D.; Kenton Waterbrook, D.O.; Barry Wickstrom, M.D.; Mark Wilson, M.D.; John Colvin, Guardian to Tim Colvin; and Debra McGoron, Guardian to Johnny Brown. The petitioners have no parent corporations or non-wholly owned subsidiaries.

Respondents

Auto Club Insurance Association, a Michigan corporation, et al.; Allstate Insurance Company, an Illinois corporation; Citizens Insurance Company of America, a Michigan corporation; Farm Bureau Insurance Company, a Michigan corporation; Farmers Insurance Exchange, a California corporation; Frankenmuth Mutual Insurance Company, a Michigan corporation; Imperial Midwest Insurance Company, a Michigan corporation, d/b/a Titan Insurance Company; Lincoln Mutual Casualty Company, a Michigan corporation; Secura Insurance Mutual Company, a Wisconsin corporation; State Farm Insurance Companies, an Illinois corporation; Transamerica Insurance Group, a California Corporation, d/b/a TIG; Wolverine Mutual Insurance Company, a Michigan corporation; Auto Owners Insurance Company, a Michigan corporation; Lahousse-Bartlett Disability Management, Inc., a Michigan Corporation, d/b/a Review Works, Rehab Works and Rehab Plans; Linkage Enterprises, Inc., a Michigan corporation, d/b/a M.I.E.S. Clinic; Manageability, Inc., a Michigan corporation, d/b/a Auditpro and Indemnicare; Medcheck Medical Audit Services, Inc., a Michigan corporation; Recovery Unlimited, Inc., a Michigan corporation, d/b/a Medical Review Systems,

TABLE OF CONTENTS

Question Presented i

Parties to Proceeding ii

Table of Contents iv

Table of Authorities vi

Opinions Below 1

Jurisdiction 1

Statutes Involved in the Case 1

Statement of the Case 5

Argument 9

I. PETITIONERS PLED SPECIFIC PREDICATE ACTS OF MAIL/WIRE FRAUD AND EXTORTION ON THE PART OF RESPONDENTS TO SUPPORT CLAIMS UNDER RICO . . . 9

A. Mail/Wire Fraud Allegations 12

B. Extortion Allegations 19

II. PETITIONERS PROPERLY ALLEGED THAT RESPONDENTS HAD ACQUIRED OR MAINTAINED AN INTEREST IN OR CONTROL OF AN ENTERPRISE THROUGH

RACKETEERING ACTIVITY 23

III. PETITIONERS PROPERLY ALLEGED INJURY TO BUSINESS OR PROPERTY AS RESULT OF RESPONDENTS HAVING ACQUIRED OR MAINTAINED AN INTEREST IN OR CONTROL OF AN ENTERPRISE THROUGH RACKETEERING ACTIVITY 24

Conclusion 25

Appendix

Appendix A
6th Circuit Court Decision - 3/15/99 . . . . . 1a

Appendix B
District Court Decision - 6/20/97 . . . . . 37a

Appendix C
Order of the District Court - 6/20/97 . . . . . 51a

TABLE OF AUTHORITIES

Page

Cases

Brownell v State Farm Mutual Insurance Company,
757 F. Supp. 526 (E.D.Pa. 1991) 17, 18, 19

Chang v Chen,
80 F.2d 1293 (9th Cir. 1996) 7

Hofstetter v Fletcher,
905 F.2d 897 (6th Cir. 1988) 8

Michaels Bldg. Co v. Ameritrust Co., N.A.,
848 F.2d 674 (6th Cir. 1988). 12, 17

People v Watson,
307 Mich. 378; 11 N.W.2d 926 (1943) 21

Shavers v Attorney General,
402 Mich. 554; 267 N.W.2d 72 (1978) 15

United States v Burks,
867 F.2d 795 (3rd Cir. 1989) 12

United States v Qaoud,
777 F.2d 1105 (6th Cir. 1985),
cert. denied, 484 U.S. 832,
108 S.Ct. 107, 98 L.Ed.2d 67 (1987) 8

Westervelt v Natural Resources Commission,
402 Mich. 412; 263 N.W.2d 564 (1978) 15

Statutes and Rules

Fed. R. Civ. P. 8(a) 12, 17

Fed. R. Civ. P. 9(b) 12, 13, 17

Fed. R. Civ. P. 12(b)(6) 7, 11

18 U.S.C.S. Section 1961(1) . . . . . *passim*

18 U.S.C.S. Section 1962(b) 2, 9, 11

Mich. Comp. Laws Section 500.3107(1)(a);
Mich. Stat. Ann. Section 24.13107(1)(a) 3, 13

Mich. Comp. Laws Section 500.3157;
Mich. Stat. Ann. Section 24.13157 . . . . . *passim*

Mich. Comp. Laws Section 750.213;
Mich. Stat. Ann. Section 28.410 . . . . . 4, 19, 21

Mich. Comp. Laws Section 445.252;
Mich. Stat. Ann. Section 19.658(2) 20, 22

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Sixth Circuit is reported at ___ F.3d ___, 1999 Fed App. 0097P (6th Cir. 1997). A copy of the Opinion is included in the Appendix at pp. 1a-36a. The Opinion of the United States District Court for the Western District of Michigan is unreported. A copy of the District Court's Opinion is included in the Appendix at pp. 37a-50a. The Order of the United States District Court for the Western District of Michigan issued on the same date is set forth in the Appendix at pp. 51a-52a.

JURISDICTION

The United States Court of Appeals for the Sixth Circuit issued its Opinion on March 15, 1999. Petitioners filed this Petition for Writ of Certiorari within ninety (90) days of the issuance of the Court of Appeals' Opinion. The jurisdiction of this Court is invoked under 28 U.S.C. §1254.

STATUTES INVOLVED IN THIS CASE

18 U.S.C.S. Section 1961 (1999).

Section 1961. Definitions.

As used in this chapter --

(1) "racketeering activity" means (A) any act or threat involving murder, kidnapping, gambling, arson, robbery, bribery, extortion, dealing in obscene matter, or dealing in a controlled substance or listed chemical (as defined in section 102 of the Controlled Substances Act), which is chargeable

under State law and punishable by imprisonment for more than one year; (B) any act which is indictable under any of the following provisions of title 18, United States Code: . . . . section 1341 (relating to mail fraud), section 1343 (relating to wire fraud) . . . .

(2) "State" means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, any political subdivision, or any department, agency, or instrumentality thereof;

(3) "person" includes any individual or entity capable of holding a legal or beneficial interest in property;

(4) "enterprise" includes any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity;

(5) "pattern of racketeering activity" requires at least two acts of racketeering activity, one of which occurred after the effective date of this chapter and the last of which occurred within ten years (excluding any period of imprisonment) after the commission of a prior act of racketeering activity . . . .

18 U.S.C.S. Section 1962 (1999).

Section 1962. Prohibited activities.

(a) It shall be unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity or through collection of an unlawful debt in which such person has participated as a principal within the meaning of section 2, title 18, United States Code, to use or invest, directly or indirectly, any part of such income, or the

proceeds of such income, in acquisition of any interest in, or the establishment or operation of, any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce. . . . .

(b) It shall be unlawful for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce.

(c) It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

(d) It shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b), or (c) of this section.

Mich. Comp. Laws Section 500.3107 (1999).

Sec. 3107. Personal protection insurance benefits; allowable expenses, work loss, personal services, waivers of coverage. (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. . . . .

Mich. Comp. Laws Section 500.3157 (1999).

Section 3157. Charges for products, services, and accommodations in treating injured persons. A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

Mich. Comp. Laws Section 750..213 (1999).

Section 750.213. Malicious threats to extort money. Any person who shall, either orally or by a written or printed communication, maliciously threaten to accuse another of any crime or offense, or shall orally or by any written or printed communication maliciously threaten any injury to the person or property or mother, father, husband, wife or child of another with intent thereby to extort money or any pecuniary advantage whatever, or with intent to compel the person so threatened to do or refrain from doing any act against his will, shall be guilty of a felony, punishable by imprisonment in the state prison not more than 20 years or by a fine of not more than 10,000 dollars.

STATEMENT OF THE CASE

This lawsuit arises out of practices engaged in by respondents when handling medical expenses *incurred by patients*, who, as auto accident victims, sought to make claims for such expenses under a no-fault policy issued by one of the respondent insurers, and *charged by providers*, who rendered treatment on behalf of such patients with the expectation that such bills would be paid in full pursuant to state no-fault law so long as the charges did not exceed the amount charged for the same service to patients with no insurance coverage.

Petitioners include forty-nine (49) individual medical providers, two (2) guardians of catastrophically injured auto accident victims, and the Advocacy Organization for Patients and Providers (hereinafter "AOPP"), a group established to be a spokesperson for both patients and providers. Respondents include thirteen (13) insurance companies, who have issued policies of no-fault insurance to persons operating motor vehicles in the State of Michigan, and five (5) review companies, who have reviewed medical bills arising out of auto accidents.

Petitioners filed this lawsuit on September 27, 1997, in the state circuit court in Eaton County, Michigan. It was subsequently removed to the United States District Court for the Western District of Michigan, Southern Division, on October 30, 1996, pursuant to 28 U.S.C. §1441, where it was assigned to the Honorable Robert Holmes Bell.

Petitioners seek declaratory relief setting forth the *rights* of insured patients and their medical providers under state no-fault law and the *duties* of insurance companies to comply with its statutory requirements. Petitioners seek to stop respondents from engaging in unlawful and unauthorized

practices when handling medical expense claims under state no-fault law.

As part of the complaint, petitioners alleged that respondents violated the Racketeer Influenced Corrupt Organizations (RICO) Act, (hereinafter "RICO), 18 U.S.C.S. Section 1961, et seq., when respondent insurance companies represented to petitioners that they would pay all reasonable charges for medical treatment of insured auto accident victims, and subsequently, respondent insurance companies, by utilizing and controlling respondent review companies, refused to fully reimburse such medical expenses, and further threatened petitioners, as medical providers, with legal action if they sought to recover unpaid balances from insured patients.

In the complaint, the actions of respondents were set forth in great detail to support these allegations. On appeal, the legal question has been whether petitioners' complaint alleged sufficient facts to support those RICO claims dismissed by the District Court.

At the outset, petitioners stress the importance of the federal issues presented in this appeal, in particular, the overriding question of whether RICO can be applied to the manner in which insurance companies (and their counterpart, medical expense review companies) fulfill their obligation to pay medical expenses on behalf of insured auto accident victims under state no-fault law.

The District Court had jurisdiction over this lawsuit under 18 U.S.C.S. Section 1964(c) which creates a civil cause of action in the district courts for persons injured under RICO. Further, the District Court had jurisdiction pursuant to 28 U.S.C.S Section 1331, which affords to the district

courts "original jurisdiction over all civil actions arising under the Constitution, laws, or treaties of the United States." Respondents filed motions to dismiss under Rule 12(b)(6) of the Federal Rules of Civil Procedure on the grounds that petitioners had failed to state a valid cause of action. Fed. R. Civ. P. 12(b)(6).

The District Court wrongly dismissed petitioners' claims under RICO on the grounds that they had not alleged sufficient facts establishing the predicate acts of mail fraud or extortion. [Appendix B, pp. 39a-44a]. Further, the District Court erroneously held that petitioners had failed to allege that there was an enterprise with an ascertainable structure separate and apart from the pattern of racketeering activity engaged in by the respondents as is required in some jurisdictions in order to properly allege a RICO claim. [Appendix B, 44a-45a]. See Chang v Chen, 80 F.3d 1293 (9th Cir. 1996); but cf. United States v Qauod, 777 F.2d 1104 (6th Cir. 1985), cert. denied, 484 U.S. 832, 108 S.Ct. 107, 98 L.Ed.2d 67 (1987).

On appeal, the Sixth Circuit Court of Appeals affirmed the District Court's ruling that petitioners had failed to plead sufficient predicate acts of fraud or extortion. [Appendix A, pp. 19a-28a]. Evidently recognizing that there is currently a split among the circuits as to whether a plaintiff must allege an enterprise with "an ascertainable structure separate and apart from the pattern of racketeering activity engaged in", the panel declined to address the District Court's ruling in this regard. [Appendix A, p. 30a FN.10].

In so doing, the Sixth Circuit avoided ruling on an issue which has not yet been resolved by this Court. Further, the panel avoided reversing what clearly was an erroneous ruling on the part of the District Court in holding that

petitioners had failed to allege an enterprise with "an ascertainable structure separate and apart from the pattern of racketeering activity engaged in" by the respondents. [Appendix B, pp. 44a-45a].

While it is well-established in some circuits that an alleged enterprise for purposes of RICO must have "an ascertainable structure separate and apart from the pattern of racketeering activity engaged in by the defendant", the Sixth Circuit has not adopted this requirement. In fact, in Qaoud, supra, p. 1116, this Court expressly held that "although 'enterprise' and 'pattern of racketeering activity' are separate elements, they may be proved by the same evidence." See also Hofstetter v Fletcher, 905 F.2d 897, 903 (6th Cir. 1988) (quoting Qauod with approval for the proposition that 'enterprise' and 'pattern of racketeering activity' may be proved by the same evidence)."

Under Qauod, it is permissible to prove these two elements of a RICO violation with the same evidence. Consequently, such claims cannot be dismissed for failing to plead sufficient facts demonstrating an enterprise separate and apart from the pattern racketeering activity so long as the plaintiff has alleged facts, which, even if the same as to both elements, nonetheless establish both an enterprise and a pattern of racketeering activity. In ruling otherwise, the District Court committed a reversible error. The Sixth Circuit refused entirely to address the issue in its opinion. [Appendix A at pp. 30a FN.10].

Notwithstanding its silence in that particular regard, the Sixth Circuit nonetheless found that petitioners had failed to allege that respondents acquired or maintained an interest in or control of an enterprise through racketeering activity. [Appendix A, pp. 29a-31a]. Further, the panel concluded that

petitioners had failed to allege an injury to business or property as a result of respondents having acquired or maintained an interest in an enterprise through racketeering activity. [Appendix A, pp. 31a-35a]. As a consequence, the Court affirmed the District Court's ruling dismissing the RICO claims in petitioners' complaint. [Appendix A, pp. 35a-36a]. It is from this erroneous ruling that petitioners are seeking a writ of certiorari from this Court.

Due to the importance of the federal issues presented in this appeal and the injustice that will result from the continuance of those practices on the part of respondents that give rise to this lawsuit, petitioners respectfully request that this Court grant certiorari in this matter which is of the utmost public importance because of its effect on both auto accident victims and those medical providers who render treatment to them.

ARGUMENT

II. PETITIONERS PLED SPECIFIC PREDICATE ACTS OF MAIL/WIRE FRAUD AND EXTORTION ON THE PART OF RESPONDENTS TO SUPPORT CLAIMS UNDER RICO.

Section 1962(b) of RICO states that "[i]t shall be unlawful for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce." 18 U.S.C.S. Section 1962(b). As such, it requires that plaintiffs allege predicate acts on the part of the defendants that constitute prohibited racketeering activities. Under section §1961(1) of

RICO, mail fraud, wire fraud and extortion are expressly defined as prohibited racketeering activities for purposes of RICO. 18 U.S.C.S. Section 1961(1).

The Sixth Circuit Court of Appeals erred by affirming the District Court's ruling which dismissed pursuant to Fed. R. Civ. P. 12(b)(6) petitioners' claims under RICO. Contrary to the Sixth Circuit's opinion, petitioners alleged specific predicate acts of both mail/wire fraud and extortion on the part of respondents. In particular, petitioners allege that, during all periods of time relevant to this case, respondent insurance companies offered to sell, and sold, policies of no-fault automobile insurance to actual and prospective applicants for such insurance which represented that they would pay all reasonably necessary charges for medical expenses resulting from an insured's involvement in an automobile accident. Understandably, insureds' and their medical providers relied upon these representations.

In actuality, however, as alleged in petitioners' complaint, respondent insurance companies had already implemented a plan in conjunction with respondent review companies, which was designed to justify their refusals to pay the full cost of products, services and accommodations stemming from an insured's involvement in an automobile accident. Subsequently, respondent insurance companies did, in fact, refuse to reimburse many of their insureds (and medical providers) for the full amount of medical costs incurred after being injured in an automobile accident. As such, respondent insurers' earlier representations as to coverage to both insureds and their medical providers were made with an intent to defraud applicants seeking to purchase no-fault automobile insurance from them.

Petitioners further allege in their complaint that

respondent insurers commit acts of fraud by sending letters to medical providers (and their patients) in which they intentionally misrepresented the requirements of state no-fault law, falsely represented that the providers' efforts to collect on unpaid medical bill balances were in violation of state and federal law, falsely purported to speak for and defend the rights of patients without first obtaining their insureds' permission, and purported to rely on a 1992 interpretation by the Michigan Insurance Commissioner of their duties to their insureds which they knew, or should have known, was not legally binding.

In addition, petitioners allege that activities of this nature on the part of respondents were all perpetrated in an attempt to discourage medical providers from recovering the full amount of their medical bills and to discourage medical providers and insured auto accident victims from seeking all necessary treatment for injuries sustained in such accidents.

When the factual allegations contained in petitioners' complaint, which support these contentions, are accepted as true, as they must be for purposes of a motion under Fed. R. Civ. P. 12(b)(6), petitioners' clearly set forth allegations of both mail and wire fraud as a specific predicate acts giving rise to their claims under section 1962(b) of RICO.

Moreover, petitioners also properly alleged extortion as a predicate act supporting their RICO claims. In particular, petitioners alleged facts supporting the conclusion that at least one respondent insurance company threatened to report medical providers to the criminal authorities for prosecution because they were attempting to collect from their insured patients on medical bills that had not been fully paid by the insurance company in accordance with its no-fault policy and the states' no-fault law. Such facts, when accepted

as true, also establish extortion as a predicate act for petitioners' RICO claims.

A. Mail/Wire Fraud Allegations

To plead mail and wire fraud violations, the plaintiff must allege (1) a scheme to defraud, (2) participation by the defendant in the scheme; 3) specific intent to defraud; and 4) the use of the mails or wires in furtherance of the scheme. United States v Burks, 867 F.2d 795 (3rd Cir. 1989). Rule 9(b) of the Federal Rules of Civil Procedure provides that in a complaint alleging fraud "the circumstances constituting fraud . . . shall be stated with particularity." Fed. R. Civ. P. 9(b). However, as the Sixth Circuit acknowledges in its opinion, the Court's own precedents instruct it to "liberally interpret Rule 9(b) against Rule 8(a)'s 'backdrop admonition of simplicity in pleading.'" Michaels Bldg. Co v. Ameritrust Co., N.A., 848 F.2d 674, 679 (6th Cir. 1988). [Appendix A, p. 12a].

In petitioners' complaint, they allege that respondent insurance companies, starting from the point in time when each insurer had arranged to have a review company audit medical bills, committed fraud with each sale of a no-fault insurance policy to an insured by intentionally misrepresenting to each policyholder that it would provide full coverage for all medical claims arising out of the insured's involvement in an automobile accident because, in actuality, respondent insurers had already implemented a plan, in conjunction with respondent review companies, to refuse payment for the full cost of such medical coverage so to minimize those amounts paid by respondent insurance companies to medical providers for treatment of auto accident victims.

There is no dispute over the fact that respondent insurance companies continued to sell no-fault insurance policies during all periods of time relevant to this lawsuit. Further, there is no question that these policies offered coverage to insureds for "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery and rehabilitation" as required by state no-fault law. Mich. Comp. Laws §500.3107(1)(a); Mich. Stat. Ann. §24.13107(1)(a). As such, it is hard to argue that the fraud allegations are not particular enough to meet the particularity requirements of Fed. R. Civ. P. 9(b).

The Michigan No-Fault Act requires that an insurance company, as part of its obligation to provide no-fault PIP benefits on behalf of an insured, pay those medical costs incurred by an insured as a result of injuries he or she sustained in a motor vehicle accident. It provides in this regard that personal protection insurance benefits are payable for the following:

> "Allowable expenses consisting of all reasonable charges incurred for the reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation." Mich. Comp. Laws § 500.3107(1)(a); Mich. Stat. Ann. § 24.13107(1)(a).

It further obligates medical providers who render treatment to persons for accidental bodily injuries covered by no-fault insurance to charge patients "a reasonable amount for the products, services and accommodations rendered." Mich. Comp. Laws § 500.3157; Mich Stat. Ann. § 24.13157.

Section 3157 of the No-Fault Act states in this regard as follows:

> "A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." Mich. Comp. Laws § 500.3157; Mich Stat. Ann. § 24.13157.

In other words, the No-Fault Act expressly prohibits medical providers from charging an insured automobile accident victim more than the amount customarily charged for the same services rendered in cases where the patient has no insurance coverage.

The Michigan No-Fault Act provides no other standard for determining whether a particular charge is a reasonable one. Consequently, all charges must be viewed as reasonable under state no-fault law, and must be paid by respondent insurance companies on behalf of their insureds, so long as the physician, hospital, or other medical provider has not charged the auto accident victim more for the same services than it would have charged when the patient had no insurance coverage.

Simply stated, state no-fault law merely places a check

on medical providers to prevent them from billing more when no-fault insurance coverage is available. Mich. Comp. Laws § 500.3157; Mich Stat. Ann. § 24.13157. In no way whatsoever does state no-fault law delegate responsibility for determining whether a particular charge is reasonable to respondents. In fact, such a delegation of authority would arguably make the act itself unconstitutional because it would violate both due process and equal protection standards.

In Shavers v Attorney General, 402 Mich. 554, 597-600; 267 N.W.2d 72 (1978), the Michigan Supreme Court made it clear that no-fault insurance companies would effectively be instruments of the state in implementing such a comprehensive legislative scheme to provide coverage to auto accident victims. Consequently, under Shavers, constitutional protections apply to respondents' actions because, in effect, they are acting as agents of the state. Id. at 439. Accordingly, respondents, in carrying out the dictates of the no-fault act, may not implement any of the state's police power that has been delegated to them without legislation creating sufficient standards for exercising such authority. See generally, Westervelt v Natural Resources Commission, 402 Mich. 412, 439; 263 N.W.2d 564 (1978), in which the Michigan Supreme Court held that such standards are required as a "check" on agency action in implementing legislation. Without such standards, acts by an agent of the state, including, as in the instant case, respondents implementing a regulatory scheme aimed at medical providers, would arguably be an unconstitutional delegation of legislative power in violation of due process and equal protection standards.

Petitioners further allege that respondent insurers perpetuated the fraud they had committed on their insureds by engaging in a course of conduct designed to further misrepresent the extent of their obligations to provide full

medical coverage to auto accident victims in accordance with the state's no-fault law. In other words, respondent insurance companies committed further fraudulent acts by sending letters to medical providers — copies of which were mailed to the providers' patients — which not only misrepresented the requirements of the state's no-fault law but also falsely represented to medical providers that their efforts to collect from their patients were somehow in violation of state and federal law.

More specifically, Petitioners allege that, as part of this effort, respondent insurers cited inapplicable statutes as authority for the proposition that medical providers could not "balance-bill" patients. Further, respondent insurers intentionally misrepresented legal precedents as supporting their refusals to pay the customary rates charged by providers for treatment of auto accident victims.

In short, respondents made intentional misrepresentations to medical providers (and their patients) in an effort to conceal the fraud perpetrated on their own insureds through the sale of no-fault insurance coverage that offered, but ultimately did not provide, full coverage to insureds for medical treatment necessitated by injuries sustained in an automobile accident. Short of filing a complaint with documentation to fill several file cabinets, the allegations set forth in the complaint could not be more particular with respect to the alleged fraud.

Moreover, given the nature of this lawsuit, it should not be surprising that the allegations of fraud are the same for each respective insurer. After all, it is Plaintiffs' contention that the unlawful and unauthorized practices giving rise to this lawsuit occurred throughout the industry, and were, in fact, performed by respondents acting in concert with each other.

As such, it is not necessary, nor is it required that Plaintiffs expand an already lengthy complaint into a several hundred page treatise in order to meet the particularity requirements of Fed. R. Civ. P. 9(b).

In other words, it is not required that petitioners set forth each instance of fraud on the part of each particular insurance company where, as in this situation, the allegations of fraud are equally applicable to each respondent insurance company and there is no real argument to be made that Defendants have not been put on notice as to the nature of the fraud allegations.

Rule 8(a) of the Federal Rules of Civil Procedure permits liberal pleading. Fed. R. Civ. P. 8(a). In fact, it calls only for "a short and plain statement of the claim" with "simple, concise and direct" allegations. Similarly, it is well recognized that the requirements of Fed. R. Civ. P. 9(b) are to be read liberally. Michaels Bldg. Co., 848 F.2d at 679. Without question, petitioners have met this pleading standard with respect to the fraud allegations in the case at bar. See Brownell v State Farm Mutual Insurance Company, 757 F. Supp. 526, 537-39 (E.D. Pa. 1991), rejecting arguments for dismissal of RICO allegations based on fraud in a lawsuit involving virtually identical facts to the case at bar.

In Brownell, the plaintiff was an insured, who, after being injured in an automobile accident, submitted medical bills to his insurance company for payment under the state's no-fault law. Subsequently, the defendant insurer disallowed the plaintiff's claim for no-fault benefits after subjecting her medical bills to an audit by the other defendant, which was a medical bill reviewing company. The plaintiff alleged that the defendants had conspired to reject, in whole or in part, claims based on a soft tissue injury such as the one she had suffered

in the underlying automobile accident. She further alleged that the fees paid to the defendant review company were based on the amount of money it saved the defendant insurance company by recommending rejection of some or all of such medical bills. Based on these factual allegations, the plaintiff alleged that the defendants had violated RICO.

The defendants in Brownell challenged whether the plaintiff had stated facts supporting a pattern of racketeering activity and/or an enterprise for purposes of RICO. The district court, however, rejected the defendants' arguments on both issues. In so ruling, the district court expressly held that the plaintiff had properly alleged predicate acts of mail fraud. The allegations of mail fraud in Brownell mirror those set forth in Plaintiffs' Complaint. On page 538 of its opinion, the district court in Brownell stated in this regard as follows:

> "Plaintiff appears to allege two schemes to defraud. The first is a scheme whereby State Farm knowingly misrepresented to prospective policyholders the availability of certain benefits, i.e., payment for treatment of injuries, including soft tissue injuries, sustained in vehicular accidents. State Farm allegedly intended *ab initio*, to limit or decline payment for the treatment of soft tissue injuries whether or not such treatment was justified. In furtherance of this alleged scheme, State Farm mailed various applications and insurance policies.
>
> Plaintiff also alleges that State Farm and Worldwide collaborated to reduce or refuse payments for treatment of soft tissue injuries regardless of the

> merits of the claims for such payments. Worldwide allegedly would evaluate such claims adversely in return for a contingency fee from State Farm which would then utilize the evaluations to support its refusal to pay the insured or provider. In furtherance of this alleged scheme, State Farm would mail requests for evaluations as well as payments to Worldwide, and the latter would mail evaluations to State Farm. This practice allegedly continued over a six-year period and victimized virtually every State Farm insured who was treated for soft tissue injury after a motor vehicle accident.
>
> The court finds that plaintiff has alleged a pattern of mail fraud sufficient to withstand a motion to dismiss."

In other words, the district court in Brownell found that factual allegations such as those made in this lawsuit do state a claim for mail fraud under RICO. In its opinion, the Sixth Circuit rejected Brownell as persuasive authority on this point in order to affirm the district court's ruling in this regard. In so doing, the Sixth Circuit committed a reversible error.

B. Extortion Allegations

Section 1961(1) of RICO provides that racketeering activity includes "any act or threat involving . . . extortion . . . which is chargeable under State law and punishable by imprisonment for more than one year." Mich. Comp. Laws §750.213; Mich. Stat. Ann §28.410 provides as follows:

> "any person who shall, either orally or by a written or printed communication, maliciously threaten to accuse another of any crime or offense . . . with intent thereby to extort money or any pecuniary advantage whatever, or with intent to compel the person so threatened to do or refrain from doing any act against his will, shall be guilty of a felony, punishable by imprisonment in the state prison not more than 20 years or by a fine of not more than 10,000 dollars."

Thus, any violation of the above-referenced state criminal statute would also constitute prohibited racketeering activity for purposes of the RICO statute.

In petitioners' complaint, letters sent to numerous medical providers by one particular respondent insurance company were quoted which specifically stated that, by balance-billing patients, such providers "may be violating the Michigan Collection Act." Such accusations on the part of that respondent are not only unfounded, they also constitute an explicit threat to report medical providers to the governmental authority that prosecutes violations of the Michigan Collection Act, in this instance, the Attorney General of the State of Michigan. Mich. Comp. Laws §445.252; Mich. Stat. Ann. §19.658(2).

In other words, at least one respondent insurance company was not simply threatening to file a civil lawsuit on behalf of its insured against any medical provider who continued to balance-bill patients — it was threatening them with criminal prosecution under Mich. Comp. Laws §445.252; Mich. Stat. Ann. §19.658(2). This particular law provides for fines up to $5,000 for a first offense of wilful

conduct violating the statute, and up to $10,000 (or imprisonment for not more than one year) for a second offense involving wilful conduct in violation of the statute. These acts were not routine business communications simply demonstrating a dispute between the parties — these letters accused certain medical providers named as petitioners in this lawsuit of criminal acts!

The simple fact is that the language of Mich. Comp. Laws §750.213; Mich. Stat. Ann. §28.410 expressly includes such threats. See People v Watson, 307 Mich. 378; 11 N.W.2d 926 (1943) (holding that extortion statute is sufficiently broad so as to cover a threat merely to publicly accuse another of a crime and does not require threat to file formal complaint and instigate a criminal prosecution). Furthermore, it should be noted that respondents routinely sent copies of these letters to their insureds (e.g. the medical providers' patient), thus arguably making public their accusations that medical providers were committing crimes by balance-billing their patients.

The Sixth Circuit, in its opinion, minimized petitioners' contentions in this regard by holding that petitioners' extortion allegations at most can be construed as "merely inform[ing] the providers that their actions may be in violation of the law." [Appendix A, p. 22a]. In so holding, the Sixth Circuit completely misunderstood the true magnitude of the "threats" made in the letters respondents addressed to medical providers who were simply attempting to collect unpaid amounts for treatment rendered on behalf of auto accident victims.

Such accusations on the part of respondents, while unfounded, nevertheless constitute an explicit threat to report medical providers to the proper governmental authority.

Further, such a threat can not be taken lightly given that violations of that Act can result in substantial fines or even imprisonment. Mich. Comp. Laws §445.252; Mich. Stat. Ann. §19.658(2). As such, Plaintiffs have alleged sufficient facts to support its claim of extortion as a predicate criminal act under RICO.

The Sixth Circuit further concluded that petitioners somehow waived this argument by failing to raise it before the District Court. [Appendix A, p. 21a-22a]. In actuality, petitioners have argued from the outset of this litigation that the language used by respondents as part of its letter-writing campaign to discourage medical providers from seeking full payment for medical treatment rendered to auto accident victims constituted "threats" rising to the level of extortion. Further, such actions injured medical providers' ability to practice medicine. See supra, pp. 25-26.

In petitioners' complaint, the accusation that medical providers "may be violating the Michigan Collection Act" was identified as an example of such threats. As such, Plaintiffs have not raised a new argument on appeal but rather they merely attempted to point out to the Court of Appeals that they alleged from the date the complaint was filed that accusations of this nature on respondents' part constitute extortion.

The Sixth Circuit evidently believes that such statements cannot be viewed as threats because of the operative sentence used the phrase "may be violating" the Michigan Collection Act. [Appendix A, p. 23a]. The simple fact is that no other plausible meaning can be given to that particular statement other than to conclude that it constitutes a threat to report someone for criminal prosecution. To suggest that respondents sought merely "to inform" the

providers of possible violations of the law is simply ludicrous on its face - respondents sought to gain an economic advantage by using threats to stop providers from seeking payment in full for medical treatment provided to auto accident victims. Such action on the part of respondents is clearly sufficient grounds to support an allegation of extortion as predicate criminal act under RICO.

II. PETITIONERS PROPERLY ALLEGED THAT RESPONDENTS HAD ACQUIRED OR MAINTAINED AN INTEREST IN OR CONTROL OF AN ENTERPRISE THROUGH RACKETEERING ACTIVITY.

The Sixth Circuit also held that petitioners failed to properly allege that respondents maintained or acquired an interest in the alleged enterprise. [Appendix A, pp. 31a-35a]. Petitioners, however, clearly alleged that the formation of review companies for the purpose of auditing medical bills in the no-fault context (and the association that developed between such review companies and no-fault insurance companies) constitutes an association-in-fact enterprise.

Without question, this enterprise could have developed (and arguably did develop) without the unlawful and unauthorized practices that have since come to dominate its dealings with medical providers and insured patients. Quite simply, this association-in-fact enterprise could have served the legitimate function of determining whether medical providers were improperly charging patients with no-fault insurance more than once for the same service. Mich. Comp. Laws §500.3157; Mich. Stat. Ann. §24.13157.

Unfortunately, as alleged in petitioners' complaint,

respondents soon acquired (or maintained) an interest in this otherwise legitimate enterprise in an effort to gain unfair economic advantage by withholding funds owed to medical providers and by discouraging medical providers from seeking to recover full payment on treatment rendered to auto accident victims.

Clearly, the "acquisition or maintenance of such an interest was accomplished by way of the racketeering activity" as alleged in petitioners' complaint. In fact, the pattern of racketeering became the cornerstone of the relationship between Defendant insurers and the review companies. As set forth in the complaint, the review companies were paid in large part based on those amounts "saved" by reducing payments to providers. Respondent insurers, in turn, saved vast sums by paying less on medical expense claims. In this manner, respondents maintained an interest in an enterprise by way of racketeering activity.

III. PETITIONERS PROPERLY ALLEGED INJURY TO BUSINESS OR PROPERTY AS RESULT OF RESPONDENTS HAVING ACQUIRED OR MAINTAINED AN INTEREST IN OR CONTROL OF AN ENTERPRISE THROUGH RACKETEERING ACTIVITY.

The Sixth Circuit further concluded that petitioners failed to allege any injury resulting from the maintenance or acquisition of an interest in the alleged enterprise. [Appendix, pp. 35a-36a]. In actuality, however, injury clearly flows from the fact that respondents have acquired an interest in this enterprise. For providers, the injury is in part a financial one. This new enterprise, when controlled through a pattern of racketeering, causes them to be paid less on their claims for medical expenses. In other words, respondents pay less than

that which petitioners bill, thereby depriving them of earned income. Further, it has caused irreparable damage to the providers' professional relationship with their patients.

For insured patients, the injury includes the adverse effect such non-payment ultimately has on the patient-provider relationship. Not surprisingly, some patients stop treating when the no-fault insurer has refused to pay in full for treatment and a balance is owed to the treating physician. As a consequence, many patients go without needed treatment for injuries sustained in automobile accidents. Further, it has resulted in extreme financial distress and fear for patients who are unable to pay for the cost of treatment when it is not paid under their policy of no-fault insurance. Without question, both providers and patients have been injured by the interest acquired by respondents in the alleged enterprise.

CONCLUSION

The Sixth Circuit Court of Appeals erred in affirming the District Court's ruling which dismissed petitioners' allegations that respondents violated RICO where respondent insurance companies represented to petitioners that they would pay all reasonable charges for medical treatment of insured auto accident victims, as required under state no-fault law, when subsequently, respondent insurance companies, acting in concert, and by utilizing and controlling respondent review companies, refused to fully reimburse such medical expenses, and threatened petitioners, as providers, with legal action if they sought to recover unpaid balances from insured patients.

Due to the importance of the federal issues presented in this appeal and the injustice that will result from the

continuance of those practices on the part of respondents that give rise to this lawsuit, petitioners respectfully request that this Court grant certiorari in this matter which is of the utmost public importance because of its effect on both auto accident victims and those medical providers who render treatment to them.

/s/_____
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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[Filed March 15, 1999]

Nos. 97-1821, 97-1832

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation, et al.,
Plaintiffs- Appellants/ Cross Appellees,

v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan Corporation, et al.;Allstate Insurance Company, an Illinois corporation; Citizens Insurance Company of America, a Michigan corporation; Farm Bureau Insurance Company, a Michigan corporation; Farmers Insurance Exchange, a California corporation; Frankenmuth Mutual Insurance Company, a Michigan corporation; Imperial Midwest Insurance Company, a Michigan corporation, d/b/a Titan Insurance Company; Lincoln Mutual

Casualty Company, a Michigan corporation; Secura Insurance Mutual Company, a Wisconsin corporation; State Farm Insurance Companies, an Illinois corporation;Transamerica Insurance Group, a California Corporation, d/b/a TIG; Wolverine Mutual Insurance Company, a Michigan corporation; Auto Owners Insurance Company, a Michigan corporation; Lahousse-Bartlett Disability Management, Inc., a Michigan Corporation, d/b/a Review Works, Rehab Works and Rehab Plans; Linkage Enterprises, Inc., a Michigan corporation, d/b/a M.I.E.S. Clinic; Manageability, Inc., a Michigan corporation, d/b/a Auditpro and Indemnicare; Medcheck Medical Audit Services, Inc., a Michigan corporation; Recovery Unlimited, Inc., a Michigan corporation, d/b/a Medical Review Systems,

Defendants-Appellees/ Cross-Appellants.

Appeal from the United States District Court for the Western District of Michigan at Lansing. No. 96-00177--Robert Holmes Bell, District Judge.

ARGUED: Linda S. Fausey, Lansing, Michigan, for Appellants. Lori M. Silsbury, Dykema Gossett, Lansing, Michigan, for Appellees. ON BRIEF: Linda S. Fausey, Lansing, Michigan, for Appellants. Lori M. Silsbury, Dykema Gossett, Lansing, Michigan, for Appellees.

Before: JONES, RYAN, and BATCHELDER, Circuit Judges.

OPINION

ALICE M.BATCHELDER, Circuit Judge.

Forty-Nine individual medical providers, two guardians of catastrophically injured auto accident victims, and a group established to be spokesperson for patients and providers ("Advocacy Organization for Patients and Providers," or "AOPP") filed a multi-count complaint against thirteen insurance companies, all of which have issued no-fault insurance polices to Michigan motorists, and five review companies, all of which have reviewed medical bills arising out of auto accidents for one or more of the insurance companies. Plaintiffs' complaint alleged, inter alia, claims under the Federal Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1962(b), against various combinations of the insurance companies and review companies, alleging that they had conspired to defraud patients and medical providers of reasonable medical fees. The district court granted Defendants' motions to dismiss, Fed.R.Civ.P. 12(b)(6), and Plaintiffs appealed. For the reasons stated below we AFFIRM the judgment of the district court.

I. PROCEDURAL HISTORY

Plaintiffs originally filed their multi-count complaint, including its 104 attached exhibits, in the state court in Michigan. The complaint alleges fifteen counts: (1) a request for a declaratory injunction as to the rights and responsibilities of the Plaintiffs under Michigan's no-fault statute; (2) a request for interim injunctive relief while the matter is

pending; (3) a request for permanent injunctive relief based on a denial of due process; (4) tortious interference with existing contractual relationships; (5) tortious interference with business relationships; (6) conspiracy to tortiously interfere with existing business and contractual relationships; (7) common law fraud; and (8)-(15), eight counts of RICO violations against various combinations of two or more of the Defendants.

The Defendants removed the case to federal district court based on federal question jurisdiction arising out of the RICO counts.

The Plaintiffs' motion to remand was denied.

The Defendants filed several motions seeking dismissal, including a "Joint Motion to Dismiss Pursuant to Fed.R.Civ.P. 12(b)" that raised lack of standing, failure to state claims in various counts (including the RICO counts), and a statute of limitations defense. On June 23, 1997, the district court dismissed the RICO counts under Rule 12(b)(6) for failure adequately to allege a predicate act upon which the Plaintiffs could base their RICO claims and failure adequately to allege a RICO enterprise. The district court also dismissed the federal due process claim for lack of state action. Finding the remaining counts based exclusively upon Michigan law, the court remanded them to the state trial court. This timely appeal followed. [1]

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[1] The Defendants filed with the district court an emergency motion to stay the order of remand pending appeal or, in the alternative, for an order vacating the order of remand, which the

In this appeal Plaintiffs challenge the district court's dismissal of their RICO claims and ask that we either reverse the district court or vacate the district court's judgment and remand the case so as to allow them to amend their complaint. Defendants ask that the district court's order remanding the state law claims be reversed in the event that we reverse the judgment dismissing the RICO counts. Because we affirm the district court's decision concerning the RICO counts, we need not address Defendants' arguments pertaining to the district court's remand order. Further, because we conclude that the RICO counts must be dismissed, we need not address Defendants' contention that they are preempted by the McCarran-Ferguson Act, 15 U.S.C.§1012.

II. STANDARD OF REVIEW

We review de novo a district court's dismissal for failure to state a claim. *Sistrunk v. City of Strongsville*, 99 F.3d 194, 197 (6th Cir.1996). To survive a motion to dismiss under Rule 12(b)(6), a "complaint must contain either direct or inferential allegations respecting all the material elements to sustain a recovery under some viable legal theory." *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 436 (6th

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court denied. Defendants filed a timely notice of cross-appeal challenging the remand of the state law claims to state court. Defendants also filed a motion with this Court to stay the remand pending the outcome of this appeal. This Court denied Defendants' motion. For ease of reference, we will refer to the Plaintiffs/Appellants/Cross-Appellees as "Plaintiffs," and the Defendants/Appellees/Cross-Appellants as "Defendants."

Cir.1988) (internal quotation marks and citations omitted).

> We must treat as true all of the well-pleaded allegations of the complaint. All allegations must be construed in the light most favorable to the plaintiff. In order for a dismissal to be proper, it must appear beyond doubt that the plaintiff would not be able to recover under any set of facts that could be presented consistent with the allegations of the complaint.

Bower v. Federal Express Corp., 96 F.3d 200, 203 (6th Cir.1996) (citations omitted). "Although this standard for Rule 12(b)(6) dismissals is quite liberal, more than bare assertions of legal conclusions is ordinarily required to satisfy federal notice pleading requirements." Scheid, 859 F.2d at 436 (citing 5 C. WRIGHT & A. MILLER, FEDERAL PRACTICE & PROCEDURE §1357, at 596 (1969)).

III. "REASONABLE" MEDICAL EXPENSES UNDER MICHIGAN'S NO-FAULT INSURANCE ACT

Michigan has a system of mandatory no-fault automobile insurance. Among other things, this system requires Michigan drivers to purchase "personal protection insurance" ("PPI"), see Mich. Comp. Laws Ann. §500.3101 (West 1993), under which "an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of [the no-fault statute]," Mich. Comp. Laws Ann.§500.3105. Specifically, coverage under PPI includes "[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured

person's care, recovery, or rehabilitation." Mich. Comp. Laws Ann. §500.3107(1)(a) (emphasis added). The statute also circumscribes the amounts that health care providers are permitted to charge for services performed for victims of auto accidents:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

Mich. Comp. Laws Ann.§500.3157 (emphasis added). These statutory provisions leave open the questions of what a "reasonable charge" is, who decides what is "reasonable," and what criteria may be used to determine what is "reasonable"--all questions at the core of this litigation. In 1992 and 1994 referenda and amendments were proposed which would have answered these questions by adding fee schedules to the no-fault act, but the proposals were not successful. *See Munson Med. Ctr. v. Auto Club Ins. Assoc.*, 218 Mich.App. 375, 554 N.W.2d 49, 56 (Mich.Ct.App.), appeal denied, 453 Mich. 959, 564 N.W.2d 887 (Mich.1996).

In late 1994 and 1995 the Michigan Court of Appeals issued two opinions that shed some light on these questions. First, in *McGill v. Auto. Assoc.*, 207 Mich.App. 402, 526

N.W.2d 12, 14 (Mich.Ct.App.1994), the court said, "When read in harmony, ss 3107 and 3157 clearly indicate that an insurance carrier need pay no more than a reasonable charge and that a health care provider can charge no more than that." The opinion spoke at length about the important "medical cost-policing" function that no-fault insurers provide and how that function would be lost if they were not required to assess for themselves the "reasonableness" of the fees medical providers charged. *See id.* at 14-15. The court expressly declined to address whether insurers could use workers' compensation schedules as part of their "reasonableness" determinations. *Id.* at 15. Six months after McGill the court decided *Hofmann v. Auto Club Ins. Assoc.*, 211 Mich.App. 55, 535 N.W.2d 529 (Mich.Ct.App.1995), appeal denied, 452 Mich. 870, 552 N.W.2d 170 (Mich.1996), which rejected Auto Club Insurance Association's ("ACIA's") argument that when a physician charges a certain amount, but receives significantly less than that from most of his patients under a Blue Cross Blue Shield Plan, then the lesser amount is the amount "customarily charged" by that physician for that procedure and is, therefore, all that the no-fault insurer is required to pay. *See id.* at 556-57. The court specifically noted, however, that the "customary charge" and "reasonableness" language in Mich. Comp. Laws Ann.§500.3157 constituted separate and distinct limitations on the amount providers may charge with respect to auto accident victims covered by no-fault insurance (that is, the "customary fee" charged by a particular provider does not define what a "reasonable fee" is); the court also noted that ACIA had not challenged the reasonableness of the particular charge at issue, basing its entire argument on what was, for that provider, a "customary charge." *Id.* at 557.

In late 1995 and 1996 the Michigan Court of Appeals shed some further light on these questions with three additional opinions. The first was *LaMothe v. Auto Club Ins. Assoc.*, 214 Mich.App. 577, 543 N.W.2d 42 (Mich.Ct.App.1995), appeal denied, 453 Mich. 930, 554 N.W.2d 916 (Mich.1996), in which the court reiterated that the insurer need pay only the "reasonable" medical expenses, rather than all of the medical expenses. *Id.* at 44. If the insurer paid expenses that were unreasonable, the court said, it would be violating the insurance contract, *id.*, and insurer scrutiny of medical charges was "compelled" by the no-fault statute, *id.* at 44 n. 3. The next opinion, *Munson Med. Ctr. v. Auto Club Ins. Assoc.*, 218 Mich.App. 375, 554 N.W.2d 49 (Mich.Ct.App.), appeal denied, 453 Mich. 959, 564 N.W.2d 887 (Mich.1996), again addressed the issue of "customary charges," *see id.* at 52. In Munson ACIA attempted to assess a provider's "customary charge" by considering what a provider received for a particular procedure under Medicare, Medicaid, Blue Cross Blue Shield, and the workers' compensation schedule. *Id.* at 54. Citing Hofmann, the court rejected ACIA's arguments stating, "ACIA's use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law." *Id.* at 56. A month after Munson was decided the court, in *Mercy Mt. Clemens Corp. v. Auto Club Ins. Assoc.*, 219 Mich.App. 46, 555 N.W.2d 871 (Mich.Ct.App.1996), appeal denied, 569 N.W.2d 168 (Mich.1997), reiterated and reaffirmed its holdings in Munson and Hofmann by rejecting an insurer's argument that it was entitled to discovery concerning a health care provider's receipt of payments from Medicare, Medicaid, Blue Cross, workers' compensation, HMOs, and PPOs so it could show the unreasonableness of the provider's bills. See *id.* at 872-74.

IV. ISSUES & DISCUSSION

According to Plaintiffs' Complaint, prior to 1989 the Defendant Insurance Companies themselves audited the fees charged by health care providers and paid claims according to what the insurance companies determined to be "reasonable." However, in 1989 the Defendant Review Companies came into existence and solicited the insurance companies' medical claim-auditing work. Plaintiffs allege that the Defendant Insurance Companies are involved in a scheme with the Defendant Review Companies to cozen medical providers and pay lower benefits to the insureds by

> knowingly appl[ying] irrelevant data, irrelevant fee schedules and other irrelevant cost data in conducting their retrospective review of medical billings, so as to either totally deny health care providers and/or insureds' requests for reimbursement, or to artificially decrease the amount [the insurers] thereafter offered to pay for such health care.

They allege that the insurers knew when they solicited the insureds to purchase the policies, that, contrary to the representations contained in those policies, the insurers did not intend to pay what would actually be the insureds' "reasonable" medical expenses, and that the Plaintiffs relied upon that "material misrepresentation" when they either bought the policies or provided medical services to those policy holders. Plaintiffs also allege that as part of this scheme, the insurance companies sent letters to medical providers who attempted to "balance bill" the insured/patients; those letters contained intentional misstatements of Michigan no-fault law, such as an assertion

that the medical providers had no claims against the insured/patients because the "reasonable costs" had been paid and that the law required the providers to seek the remainder from the insurer. Further, Plaintiffs claim that some of the Defendants threatened to defend their insureds against the medical providers' debt-collection attempts against the insured/patients. Plaintiffs' multiple RICO counts are premised upon these alleged actions.

In order to state a RICO claim, Plaintiffs must allege an injury to their "business or property by reason of a violation of section 1962 of this chapter."[2] Plaintiffs claim violations only under 18 U.S.C. § 1962(b), which makes it unlawful for "any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce." 18 U.S.C.§1962(b). Thus, to state a claim under§1962(b), Plaintiffs must plead facts tending to establish that Defendants

(1) acquired or maintained
(2) through a "pattern of racketeering activity" or the "collection of an unlawful debt"
(3) an interest in or control of an enterprise
(4) engaged in, or the activities of which affect, interstate or foreign commerce.

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[2] 18 U.S.C. § 1964(c). "Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee...." *Id.*

A. "RACKETEERING ACTIVITY" AND PREDICATE ACTS

"In order to establish 'racketeering activity' the plaintiffs must allege a predicate act," *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 389 (6th Cir.1996), under 18 U.S.C. § 1961(1). Plaintiffs alleged mail and wire fraud, 18 U.S.C. §§ 1341, 1343, in all of their RICO counts, and extortion, Mich. Comp. Laws Ann. § 750.213, in two of their RICO counts; mail and wire fraud and extortion are included in the definition of "racketeering activity" in § 1961. *See* § 1961(1)(A) (listing extortion chargeable under State law); § 1961(1)(B) (listing violations of 18 U.S.C. §§ 1341, 1343).

1. Mail/Wire Fraud: Rule 9(b) of the Federal Rules of Civil Procedure provides that in a complaint alleging fraud, "the circumstances constituting fraud ... shall be stated with particularity." Fed.R.Civ.P. 9(b). The purpose of Rule 9(b) is to provide fair notice to the defendant so as to allow him to prepare an informed pleading responsive to the specific allegations of fraud. *Michaels Bldg. Co. v. Ameritrust Co.*, N.A., 848 F.2d 674, 679 (6th Cir.1988). The Sixth Circuit reads rule 9(b)'s requirement "liberally, ... requiring a plaintiff, at a minimum, to allege the time, place, and content of the alleged misrepresentation on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *Coffey v. Foamex L.P.*, 2 F.3d 157, 161-62 (6th Cir.1993) (internal quotation marks and citation omitted). This liberal reading stems from the influence of Rule 8, which "requires a 'short and plain statement of the claim,' and calls for 'simple, concise, and direct' allegations." *See id.*; *Michaels Bldg. Co.*, 848 F.2d at 679 (quoting Fed.R.Civ.P. 8(a), (e)). Even against Rule 8's

"backdrop admonition of simplicity in pleading," *id.*, "[h]owever, allegations of fraudulent misrepresentation[s] must be made with sufficient particularity and with a sufficient factual basis to support an inference that they were knowingly made." *Coffey*, 2 F.3d at 162 (internal quotation marks and citation omitted).

The elements of mail and wire fraud are: (1) a scheme to defraud, and (2) use of the mails, or of an interstate electronic communication, respectively, in furtherance of the scheme. *United States v. Brown*, 147 F.3d 477, 483 (6th Cir.), *pet'n for cert. filed*, No. 98-5835 (Aug. 27, 1998).

> A scheme to defraud consists of intentional fraud, consisting in deception intentionally practiced to induce another to part with property or to surrender some legal right, and which accomplishes the designed end. *To allege intentional fraud, there must be proof of misrepresentations or omissions which were reasonably calculated to deceive persons of ordinary prudence and comprehension. Thus, the plaintiffs must allege with particularity a false statement of fact made by the defendant which the plaintiff relied on.*

Kenty, 92 F.3d at 389-90 (emphasis added) (internal quotation marks, modification and citations omitted).

Plaintiffs' complaint avers that the Defendants made two misrepresentations in furtherance of their alleged scheme to defraud. The first was the insurance companies' statements to prospective insureds that the insurance companies would

pay all of the insured's reasonable and necessary medical charges arising out of automobile accidents. *See, e.g.*, J.A. at 162 (Complaint ¶ 168(a)). The second was the insurance companies' and/or the review companies' statements to the health care providers, after the insureds' claims had been reviewed and discounted, that the amount the insurers had paid the providers was all the providers were entitled to receive under Michigan law. *See, e.g.*, J.A. at 163 (Complaint ¶ 168(d)). We address each in turn.

To support their claim that Defendants misrepresented their intention to pay for their insureds' reasonable auto accident-related medical expenses, Plaintiffs first alleged that the Defendants intended to accomplish their fraud through the knowing use of "irrelevant data, irrelevant fee schedules and other irrelevant cost data in conducting their retrospective review of medical billings, so as either to deny totally health care providers and/or insureds' requests for reimbursement, or artificially decrease the amount [the insurer] thereafter offered to pay for such health care," J.A. at 163, 166-67, 169, 173, 176, 178-79, 181, 184 (Complaint ¶¶ 168(c), 176(c), 183(c), 191(c), 198(c), 205(c), 212(c), 219(c)). The only factual support for this specific allegation appears in paragraphs 76 and 78 of the Complaint, J.A. at 122-24, which refer to the Complaint's attached Exhibits 28 and 30. Exhibit 28 is a detailed printout of a ManageAbility claim assessment, date-stamped January 7, 1993, denying full payment on a particular medical claim and stating, "Our data base, which includes input from peers for the same services,
normal reimbursement from health care insurances, H.I.A.A. tables, and relative value studies at the local and regional level, suggest [sic] that this reimbursement is reasonable and customary, and complies with section 3107 of the No-Fault

Law." J.A. at 264 (Complaint Ex. 28). Exhibit 30 is a letter, dated December 30, 1992, from ManageAbility to a health care provider which states, "Our assessment of what constitutes reasonable charges is not, as you suggest, arbitrary, but rather is determined by comparing several different data sources and then identifying what is reasonable to our client." J.A. at 266 (Complaint Ex. 30). Attached to this letter is a document entitled "Determination of Reasonable and Customary Charges," which states:

> ManageAbility uses several different sources of data to identify reasonable and customary medical fees. Among these are the HIAA (Health Insurance Association of America) tables, various health plan reimbursement schedules such as Blue Cross Blue Shield of Michigan, SelectCare, Health Alliance Plan (HAP), and the Michigan Workers' Compensation Fee Schedule. Most importantly, we collect and analyze billing data from peer providers for like procedures throughout the state of Michigan.
>
> ManageAbility compares provider charges against all of these data sources and then recommends reimbursements that are slightly higher than those of the group health plans, but certainly in line with their peers' average charges. At the providers' request the remuneration for a specific procedure will be judged by a member of our professional staff practicing in the same specialty.
>
> Our data are updated quarterly, but individual adjustments are made periodically

on an as-needed basis.

J.A. at 268 (Complaint Ex. 30).

Plaintiffs' Complaint contains no facts supporting their allegation that these factors are "irrelevant." Review of Michigan's case law, see supra Part II, reveals that the Michigan courts have not found some of these factors, such as HIAA tables and billing data from peer providers, irrelevant; furthermore, the state courts did not issue opinions calling the other factors into question until a few weeks before this lawsuit was commenced on September 23, 1996,[3] years after the correspondence cited by Plaintiffs was sent. The fact that the Defendants considered this data back in 1992 does not raise an inference that they did so as part of scheme to defraud their insureds and health care providers by using the data to assess the reasonableness of medical fees, or that the insurance companies' offers to pay for the insureds' "reasonable" PPI medical claims, as required under the statute, were knowingly false when made.

The only other arguable factual support for Plaintiffs' claim that Defendants misrepresented their intention to pay their insureds' reasonable medical expenses is the Plaintiffs' assertion that the fees paid by the Defendant Insurance Companies to Defendant Review Companies are

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[3] Indeed, although Munson was decided on August 23, 1996, it was not released for publication until October 15, 1996. *See Munson Med. Ctr. v. Auto Club Ins. Assoc.*, 218 Mich.App. 375, 554 N.W.2d 49, 49 (Mich.Ct.App.), appeal denied, 453 Mich. 959, 564 N.W.2d 887 (Mich.1996).

"contingent upon the amount of savings (in the form of decreased payments to health care providers) the review companies' analyses yield[ ] for their insurance company clientele." J.A. at 118-19 (Complaint). While one might infer from such a fee arrangement the *potential* for fraud, Plaintiffs have failed to allege any fact--other than the mere existence of this fee arrangement--from which one could infer that the insurance companies and the review companies actually participated in a scheme to defraud the Plaintiffs.[4] As a matter of law we find that this bare allegation, without more, fails to meet the requirements of Rule 9(b). The mere possibility that an otherwise lawful payment system could be used to defraud does not create a inference of fraud sufficient to withstand a 12(b)(6) motion. *But see Brownell v. State Farm Mut. Ins. Co.*, 757 F.Supp. 526, 538-39 (E.D.Pa.1991) (finding such a payment arrangement sufficient to plead a scheme to defraud).[5]

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[4] Additionally we note that only against Defendant Linkage Enterprises, Inc. does the Complaint specifically allege this fee arrangement. As for the other review companies, it alleges the existence of such an arrangement only "upon information and belief."

[5] In Brownell, the district court found, under facts somewhat similar to those alleged in the case before us here, that the complaint adequately stated a RICO cause of action against an insurer and a medical claim review company. In its assessment of whether the plaintiff had sufficiently alleged the predicate act of mail fraud, the opinion never mentions Fed.R.Civ.P. 9(b), see Brownell, 757 F.Supp. at 537-39, and we do not think its holding is correct in light of the slightly more involved scrutiny that must be applied under Rule 9(b) as opposed to the general pleading

The second alleged misrepresentation made by Defendants was the insurance companies' and/or the review companies' statements to the health providers, after the insureds' claims had been reviewed and discounted, that the amounts the providers had received were all they were entitled to receive under Michigan law. J.A. at 163, 166, 169, 173, 176, 179, 182,184-85 (Complaint ¶¶ 168(d), 176(d), 183(d), 191(d), 198(d), 205(d), 212(d), 219(d)). Assuming the Defendants' letters may be read to say this, Plaintiffs have not alleged facts which would support the inference that such statements were false. They have alleged no facts tending to show that the fees charged by the providers were "reasonable" (or that the amounts paid by the insurance companies were "unreasonable"), and Michigan law clearly states that health care providers are permitted to charge only a "reasonable" amount for auto-accident related medical care when the patient is covered by no-fault insurance, see Mich. Comp. Laws Ann. § 500.3158; *McGill v. Automobile Assoc.*, 207 Mich.App. 402, 526 N.W.2d 12, 14 (Mich.Ct.App.1994) ("[M]edical care providers are prohibited by law from charging more than a reasonable fee."). Thus, what the providers received from the Defendants may very well have been all they were entitled to receive under Michigan's

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requirements of Rule 8(a). While our precedent has stated that we liberally interpret Rule 9(b) against Rule 8(a)'s "backdrop admonition of simplicity in pleading," *Michaels Bldg. Co. v. Ameritrust Co.*, N.A., 848 F.2d 674, 679 (1988), this precedent does not hold that Rule 8(a) nullifies Rule 9(b). Accordingly, to the extent that Brownell would counsel an outcome different from the one we reach here, we specifically disapprove the holding in Brownell.

no-fault act. Other than their general allegation of fraud, Plaintiffs allege no facts indicating that the providers' fees, rather than the insurance companies' payments, were the "reasonable" figures; the general allegation is not sufficient to satisfy Rule 9(b). The "reasonableness" of these charges is a legal conclusion, wholly unsupported by allegation of fact, and therefore it need not be accepted as true for purposes of 12(b)(6) review.

The district court did not err in holding that the complaint did not sufficiently plead mail and/or wire fraud as a predicate act.

2. Extortion: In Counts 8 and 10 of Plaintiffs' multiple RICO counts Plaintiffs also allege the predicate act of extortion. The factual allegations supporting these claims derive from letters sent by Defendants ACIA (Count 8) and Auto-Owners (Count 10) threatening litigation if the providers continued to bill the patient/insureds for the difference between the amount charged by the provider and the amount paid by the insurer ("balance billing").

To be guilty of extortion under Michigan law, one must:

> (1) maliciously threaten, orally or by written or printed communication;
> (2) either
>
> > (a) to accuse another of any crime or offense or
> > (b) to cause injury to the person or property or mother, father, husband, wife or child of another;

> (3) with intent thereby either to
>
> (a) extort money or any pecuniary advantage whatever, or
>
> (b) compel the person so threatened to do orrefrain from doing any act against his will.

See Mich. Comp. Laws Ann. § 750.213.

The district court found that the only "threats" alleged by Plaintiffs were the Defendants' statements indicating their intent to bring civil actions against the providers if they continued to balance bill the patient/insureds, as the Defendants believed that under Michigan law the dispute over the unpaid balance was between the insurance company and the provider, rather than between the provider and the patient/insured. Accordingly, the district court dismissed the extortion allegation, finding that under Michigan extortion law, a threat to bring a civil suit to enforce one's rights cannot give rise to an action under the extortion statute. *See Various Mkts., Inc. v. Chase Manhattan Bank*, 908 F.Supp. 459, 468 (E.D.Mich.1995).

Appellants do not challenge the holding of the district court. Rather, they claim that the district court overlooked the fact that the Defendants also threatened *to accuse the providers of crimes* if they continued to balance bill the patients/insureds, and such a threat satisfies the Michigan extortion statute. *See People v. Watson*, 307 Mich. 378, 11 N.W.2d 926, 928 (Mich.1943) ("We believe the statute is sufficiently broad so as to cover a threat merely to publicly accuse another of a crime and that it does not require a threat to file formal complaint and instigate a criminal

prosecution."). Appellants' argument is not well taken.

First, Appellees contend that Appellants' "threaten to accuse them of crimes" argument was not raised below and is therefore waived. Appellants respond that their complaint clearly alleges that the insurers' letters contained the statement that the providers "may be violating the Michigan Collection Act," and also that they have argued from the outset that the letters constituted "threats" rising to the level of extortion. This argument is not "new", they contend; rather it merely "expounds" on the same argument made earlier. (Appellant's Reply Br. at 17 n. 1.)

The purpose behind the waiver rule is to force the parties to marshal all of the relevant facts and issues before the district court, the tribunal authorized to make findings of fact. *See Hormel v. Helvering*, 312 U.S. 552, 556, 61 S.Ct. 719, 85 L.Ed. 1037 (1941).[6] The notion that the statement "you may be in violation of the Michigan Collection Act if you continue to [do a particular act]" amounts to a threat to

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[6] In Hormel the Court stated:

> Ordinarily an appellate court does not give consideration to issues not raised below. For our procedural scheme contemplates that parties shall come to issue in the trial forum vested with authority to determine questions of fact. This is essential in order that parties may have the opportunity to offer all the evidence they believe relevant to the issues which the trial tribunal is alone competent to decide; it is equally essential in order that litigants may not be surprised on appeal by final decision there of issues upon which they have had no opportunity to introduce evidence. 312 U.S. at 556.

accuse someone of a crime is anything but obvious, and the forum in which the Plaintiffs were required to urge this interpretation of the facts was the trial court. Accordingly, we agree with the Appellees' assertion that it is appropriate for us to apply the waiver rule in this instance.

Second, even if this argument was not waived, the statements made by the Defendants in the letters at issue cannot be construed as "threats to accuse the providers of crimes." Rather, they merely inform the providers that their actions may be in violation of the law. The Joint Appendix contains only Auto-Owners letter discussing "illegality;" that letter says, "Under Michigan Law, when a bill is in dispute, it is illegal for you to send them to collections. We ask that you cease with this action immediately." J.A. at 263 (Ex. 27). All of the ACIA letters referred to by Appellants, except one, state:

> Our attorneys have advised us that if you continue to balance-bill our insured or report to a collection agency or credit reporting company that our insured has a delinquency, *you may be violating the Michigan Collection Act* and/or the Fair Credit Reporting Act and you may be subject to tort damages for libel and slander. To repeat, our insured has no liability in this matter. If you bring a lawsuit against our insured, we will defend and indemnify [him/her or them].

J.A. at 275-87 (Ex. 37-47) (emphasis added). These statements fall far short of threatening to make a public accusation that the providers are committing a crime. We note that ACIA did send an additional letter to one provider in

response to his continued attempt to balance bill a patient/insured:

> Again it has come to our attention that you are "balance billing" our insured. I also note you have been advised by letter that neither our insured nor we are responsible for these additional charges.
>
> I highly recommend that you cease with your threats to the Wallaces. If you continue with your current position, *you will be violating the Michigan Collection Act* and/or the Fair Report Act and may be subject to tort damages for libel or slander.
>
> If, in fact, you decide to report this to a collection agency, we will immediately act in the insured's behalf to have this removed and any action taken against the insured will result in our providing a defense.
>
> You have been previously advised of your appeal process with the reviewing company. It is recommended that you pursue that option. Your dispute rests with them or the Auto Club, not with the insured.

J.A. at 288 (Ex. 48) (emphasis added). Although this letter uses the words, "will be violating" rather than "may be violating," it does not threaten to accuse the provider of committing a crime.[7] In fact, the only threat this letter could

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[7] We also observe that at least one of the Plaintiffs did to a Defendant the very thing that the Appellants are now claiming to

be construed to make is that the insurance company would defend the insured if legal actions were pursued by the provider--hardly a threat at all, let alone a threat to accuse the provider of a crime.

Third, the threat must be "malicious." In *People v. Watson*, 307 Mich. 378, 11 N.W.2d 926, the female defendant engaged in an extramarital affair with the male victim, claimed to have become pregnant, asked for and received money from the victim for an illegal abortion, and then sent the victim a series of notes demanding more money for treatment of medical complications that she said had resulted from the abortion. After sending her numerous payments, the victim finally told her he could do no more, and the defendant threatened,

> Do you want me to go to the County House for this treatment? I am ready to air the whole

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be "extortion." Dr. Paul Kenyon wrote to ManageAbility,

> Please be advised that if our patients are categorically told that our charges "are unreasonable," we will take legal action against any company whose representative(s) make such statements. Our attorney has advised us that such statements constitute slander, defamation, interference with contractual relationships, interference with prospective business relationships, and a violation of various deceptive trade practices acts.

J.A. at 265 (Ex. 29; emphasis added).

> thing--as I am doing the suffering--not you. If you don't--what other course have I--as if it wasn't for you I could tell him[8] all--as I don't care for myself. If you do not reply to this I will send him to come here and bring an attorney with him as I can't go on like this. You must know this is terrible. I can't help the condition--as you made me get rid of same--paid for it--and left me in this condition.

Id. at 927. In fact, the defendant had neither been pregnant nor had an abortion, and the whole scheme had been concocted to extort money from the victim. *This* is a "malicious" threat to accuse one publicly of a crime.

In contrast, Plaintiffs have pled no facts sufficient to raise an inference that the Defendants acted with a malicious intent when they sent the letters at issue. Indeed, Plaintiffs attached to their Complaint an "Interpretive Statement" issued on October 23, 1992, by Michigan's Commissioner of Insurance, David J. Dykhouse, entitled "In the matter of Disputes Between No-Fault Automobile Insurers and Health Care Providers" which, after quoting Mich. Comp. Laws Ann. § 500.3107(1)(a) in toto, stated:

> The Insurance Bureau has received reports that no-fault insurers have questioned the reasonableness of some of the charges billed by health care providers for services

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[8] "Evidently, 'him' referred to defendant's husband." Watson, 11 N.W.2d at 927.

rendered to their insureds and claimants following a motor vehicle accident. In some instances where the insurer and the provider have been engaged in such a dispute, the health care provider has billed the patient for the disputed amount and has vigorously pursued collection from the insureds or claimant directly.

The purpose of this bulletin is to remind no-fault insurers that they are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance. Auto insurers must act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit, or lawsuit as a result of a dispute between the health care provider and the insurer.

When such a dispute arises, an insurer will meet its statutory obligations by adhering to the following procedures. First, the insurance company must assume its statutory responsibility for complete protection of the insured. To do so, the insurer should notify the provider that the insurer is responsible for paying any reasonable charges, not the insured or claimant. Second, the insurer must also assure the policyholder or claimant of its responsibility. Insureds and claimants should be given directions on how to handle any bills or collection notices they receive. Third, the insurer should notify collection agencies and

> credit reporting agencies to disregard medical providers' claims against the insured for services covered under personal injury protection benefits. And finally, health care providers should be warned that the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection.
>
> A dispute between a medical provider and the insurer as to the reasonableness of the charge for services does not void the insurer's obligation to its insureds and claimants to pay the amount ultimately determined to be reasonable. The insurer also has an obligation to protect its insureds and claimants from any consequences of such a dispute.

J.A. at 261-62 (Complaint Ex. 26). An insurer reading this directive would have every reason to believe it his obligation to send the letters that the Plaintiffs now claim were extortionate. Plaintiffs argue that the Commissioner's Bulletin is irrelevant to their claim that Defendants acted with malice because the Bulletin does not have the force and effect of law and, therefore, Defendants' belief that it imposed a binding obligation on them was unfounded. That argument is without merit.[9] Even if such a bulletin lacks the force of law, it would

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[9] *See McGill v. Automobile Assoc.*, 207 Mich.App. 402, 526 N.W.2d 12 (Mich.Ct.App.1994):

certainly have lulled even the most skittish--or cynical--of insurers into believing that the sending of letters that complied with the bulletin's requirements was not a malicious act.

The district court did not err in finding that the complaint did not sufficiently plead extortion as a predicate act.

B. ACQUIRING OR MAINTAINING AN INTEREST IN OR CONTROL OF AN ENTERPRISE THROUGH RACKETEERING ACTIVITY

> [D]efendants have expressly stated that they will defend and indemnify plaintiffs in the event that plaintiffs are sued by their providers for the outstanding balance. *Indeed they are directed to do so by a recent Interpretive Statement issued by the Commissioner of Insurance. It requires that no-fault insurers provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance.*

Id. at 14 (emphasis added) (footnote omitted). The court stated in the footnote, "While the Commissioner of Insurance's Interpretive Statement, Bulletin 92-03, does not have the full force and effect of law, we generally give deference to administrative agency interpretations." *Id.* at 14 n. 1 (citations omitted).

A violation of § 1962(b) requires that the RICO defendant acquire or maintain an interest in, or control of, an enterprise through (or by way of) the pattern of racketeering activity. *Compagnie de Reassurance D'Ile de France v. New England Reinsurance Corp.*, 57 F.3d 56, 91-92 (1st Cir.), *cert. denied*, 516 U.S. 1109 (1995); *Lightning Lube, Inc. v. Witco Corp.*, 4 F.3d 1153, 1189-90 (3d Cir.1993); *Danielsen v. Burnside-Ott Aviation Training Ctr.*, 941 F.2d 1220, 1230-31 (D.C.Cir.1991); *see also BancTraining Video Sys. v. First Am. Corp.*, 956 F.2d 268, 1992 WL 42345, at *5 (6th Cir. Mar.3, 1992) (per curiam). In their motion to dismiss, Defendants argued that the Plaintiffs did not adequately plead this element of a RICO violation. The district court, however, found that because it was dismissing the case for failure sufficiently to allege predicate acts or an enterprise, it did not need to address this argument. When reviewing a district court's dismissal under Fed.R.Civ.P. 12(b)(6), an appellate court may affirm the district court's decision on any ground supported by the record, even if different from the grounds relied on by the district court. *Andrews v. Ohio*, 104 F.3d 803, 808 (6th Cir.1997) (citing *City Management Corp. v. U.S. Chem. Co., Inc.*, 43 F.3d 244, 251 (6th Cir.1994); *Russ' Kwik Car Wash, Inc. v. Marathon Petroleum Co.*, 772 F.2d 214, 216 (6th Cir.1985)). We think it is important to address this argument as well.

Defendants are correct. Plaintiffs' RICO counts are entirely silent with regard to *how* Defendants acquired or maintained an interest in or control of the enterprise, namely the association of the insurance company and the review

companies,[10] through the alleged racketeering activity, namely mail/wire fraud and in some cases extortion. Rather, they simply parrot the language of the RICO statute by stating, "From at least 1992 forward, Defendants [insurance company and review company or companies] associated together to maintain, directly or indirectly, an interest in and/or control of an enterprise which was engaged in a pattern of racketeering activity...." J.A. at 162, 166, 169, 172, 175, 178, 181, 183-84 (Complaint ¶¶ 168, 176, 183, 191, 198, 205, 212, 219). This is nothing more than a conclusion, and the complaint alleges no facts in support of it. Furthermore, this parroted language complains that Defendants associated together *in order to* engage in the pattern of racketeering activity, not that they acquired their interests in or control of the enterprise *through* the racketeering activity. In *Lightning Lube* the Third Circuit stated:

> Furthermore, Lightning Lube's RICO pleadings fail to "allege a specific nexus between control of any enterprise and the alleged racketeering activity, as required under section 1962(b)." Instead, Lightning Lube merely avers that Witco and Avis maintain an interest in themselves and the joint venture.

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[10] The district court specifically held that the Plaintiffs had failed to adequately plead the existence of a RICO enterprise.

We will not address that holding, as we must affirm its dismissal of the case due to Plaintiffs' failure to adequately plead other necessary RICO elements. For purposes of the following analysis, we assume without deciding that Plaintiffs sufficiently pled a RICO enterprise.

> This allegation does not explain how such an interest is the result of racketeering as opposed to an interest derived from Witco and Avis's legitimate activities, and is thus insufficient.

4 F.3d at 1191 (emphasis added and citations omitted) (quoting *Banks v. Wolk*, 918 F.2d 418, 421 (3d Cir.1990)). Plaintiff's Complaint wholly fails to plead this element of a violation of § 1962(b).

C. Injury to business or Property "By Reason of" A Violation of§1962(b)

Finally, Plaintiffs fail to allege that they were injured by reason of the Defendants' acquisition or maintenance of an interest in or control of the enterprise. The civil remedy created by § 1964(c) authorizes recovery only for injury that a plaintiff suffers "by reason of" the RICO violation; therefore, a complaint for violation of § 1962(b) must allege an "acquisition or maintenance" injury separate and apart from the injury suffered as a result of the predicate acts of racketeering activity. *Danielsen*, 941 F.2d at 1231. The First Circuit in *Compagnie de Reassurance D'Ile de France* found such a flaw fatal:

> Under § 1962(b), the plaintiffs had to show that they were harmed by reason of NERCO's acquisition or maintenance of control of an enterprise through a pattern of racketeering activity. Again, even assuming that plaintiffs proved the underlying RICO violation, they failed to prove any harm *beyond that resulting from the fraud which*

constituted the predicate act.

57 F.3d at 92 (emphasis added); *see also Danielsen*, 941 F.2d at 1231 ("Plaintiffs do not allege that their purported injury (underpayments of wages and benefits) was caused by the acquisition of an enterprise.... [P]laintiffs allege ... simply that their injuries result from 'the intentional and continuous underpayment of legally required minimum wages and fringe benefits.' "); *but cf. Craighead v. E.F. Hutton & Co., Inc.*, 899 F.2d 485, 494 (6th Cir.1990) (stating that plaintiffs' § 1962(a) claim fails "because they have not alleged injuries stemming directly from the defendants' alleged use or investment of their illegally obtained income. *Unlike section 1962(c), subsection (a) requires such a separate and traceable injury, and plaintiffs have alleged only injuries traceable to the alleged predicate acts.")* (emphasis added).

The Eastern District of Michigan concluded that a complaint nearly identical to the Plaintiffs' failed to allege the requisite injury to state a claim under § 1962(b):

> Similar to § 1962(a), in order to allege injury "by reason of" § 1962(b), a RICO plaintiff must demonstrate that the defendant's acquisition or control of an interstate enterprise injured plaintiff. In other words, injury from the racketeering acts themselves is not sufficient; rather, a plaintiff must plead facts tending to show that the acquisition or control of an interest injured plaintiff.
>
> In the case at bar, plaintiffs allege as follows:
>
> That the defendants through a pattern of racketeering activity have acquired and

> maintained directly or indirectly an interest in or control of the enterprise, said enterprise engaged in and involved in the activities of which affect the interstate or foreign commerce is prohibited under 18 U.S.C. § 1962(b).
>
> As with their § 1962(a) claim, plaintiffs' § 1962(b) claim essentially states that plaintiffs were injured by defendants' acts of racketeering. The amended complaint contains conclusory allegations which parrot each of the four parts of § 1962. Plaintiffs' complaint fails to allege that their injury resulted from the acquisition or control of an interest by defendants....
>
> In sum, the proximate cause of plaintiffs' injuries as alleged in their complaint is defendants' alleged acts of racketeering themselves. Therefore, plaintiffs' RICO claims brought under § 1962(a) and (b) do not satisfy the requirement that the injury be "by reason of" the use or investment, or the acquisition or control of an interest.

DeLorean v. Cork Gully, 118 B.R. 932, 946 (E.D.Mich.1990) (citation omitted); *see also South Carolina Elec. & Gas Co. v. Westinghouse Elec. Corp.*, 826 F.Supp. 1549, 1562 (D.S.C.1993). The Eastern District of Michigan reiterated this holding in *Whaley v. Auto Club Ins. Assoc.*, 891 F.Supp. 1237 (E.D.Mich.1995), aff'd, 129 F.3d 1266, 1997 WL 729451 (6th Cir. Nov. 12, 1997) (unpublished per curiam):

> [A]ccording to 18 U.S.C. § 1964(c), plaintiff can only seek a civil remedy under RICO if her business or property was injured by reason of the § 1962(b) violation. Contrary to plaintiff's assertion, one does not violate § 1962(b) by committing mail fraud or extortion. Instead, one must use racketeering activity to gain control or interest in an enterprise. In other words, plaintiff cannot simply allege that she was injured by the underlying acts of mail fraud and extortion. Rather, she must allege that she was injured by a violation of § 1962(b). In this case, in order to be injured by a violation of § 1962(b), plaintiff must show that her alleged injuries resulted from Auto Club having maintained an interest in itself as an enterprise.

Whaley, 891 F.Supp. at 1242; *see also id.* at 1242-43 (discussing how *Sedima, S.P.R.L. v. Imrex Co., Inc.*, 473 U.S. 479, 105 S.Ct. 3292, 87 L.Ed.2d 346 (1985), did not compel a different outcome).

The Plaintiffs here have alleged only injury resulting from the "scheme to defraud" or "scheme to extort" (*i.e.*, the racketeering activity), rather than from the acquisition of an interest in or control of the alleged enterprise. *See, e.g.*, J.A. at 168 (Complaint ¶ 179) ("The above described scheme to defraud both the Plaintiff insureds, and ... health care providers, conducted by the enterprise as described above, has caused the Plaintiff insureds and the Plaintiff health care providers to suffer damages...."); J.A. at 171 (Complaint ¶ 187) ("The above described scheme to ... attempt to extort

acts or omissions against the wills of health care providers, conducted by the enterprise described above, has caused the Plaintiff insureds and the Plaintiff health care providers to suffer damages....").

As we have heretofore explained, Plaintiffs have wholly failed to allege any facts sufficient to state a claim for violation of § 1962(b), i.e., that Defendants acquired or maintained, through a pattern of racketeering activity, an interest in an enterprise. It follows, therefore, that they have not alleged any injury by reason of such violation.

CONCLUSION

Because Plaintiffs' complaint does not adequately allege predicate acts constituting "racketeering activity," or allege that Defendants acquired or maintained any interest in or control of an enterprise through racketeering activity, or that Plaintiffs suffered injury as a result of Defendants' acquiring or maintaining an interest in or control of an enterprise through racketeering activity, we AFFIRM the district court's dismissal of Plaintiffs' complaint for failure to state a claim upon which relief could be granted, Fed.R.Civ.P. 12(b)(6).

We decline to remand this case to the district court to permit Plaintiffs to amend their complaint. It is clear from the voluminous Complaint and its 104 attached exhibits that Plaintiffs cannot state a claim that any of the Defendants violated § 1962(b) and that Plaintiffs suffered injuries as a result. *Cf. EEOC v. Ohio Edison Co.*, 7 F.3d 541, 546 (6th Cir.1993) (quoting *Bank v. Pitt*, 928 F.2d 1108, 1112 (11th Cir.1991), for the proposition that "[w]here *a more carefully*

drafted complaint *might* state a claim, a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice") (emphasis added). Indeed, it is clear that what Plaintiffs have sought to cast as RICO violations are in fact disputes over who was entitled to determine what "reasonable" means in the world of health care costs. The crux of Plaintiffs' complaint is that whatever a "reasonable charge" might be in any given circumstance, the Defendants intended at all times not to pay that amount. We think that where the law requires that the Defendants pay only the reasonable costs, but does not require reasonableness to be determined by some neutral party and contains no standards whatsoever for gauging what is reasonable, an allegation that the Defendants promised to pay the reasonable charge while intending to pay less than the reasonable charge cannot even state a claim for fraud as a matter of law.

APPENDIX B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed June 20, 1997]

Case No. 5:96-CV-177

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation, et al.,
Plaintiffs,

v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan Corporation, et al.,
Defendants.

OPINION

Before the Court are a number of Rule 12(b) motions filed by (1) the Defendant insurance companies, (2) Defendant Review Works, (3) Defendant TIG Insurance and (4) Defendant State Farm Insurance. These motions are joined by Defendants Manageability, Medaudit and Recovery Unlimited. The underlying action is brought by Advocacy Organization for Patients and Providers, a number of

individual doctors, and two patients against the Defendant insurance and review companies. This matter arises out of a dispute over the interpretation of Michigan's no-fault motor vehicle protection statute and the, roles of health care providers, insurance companies, and review companies under that statute.

The portions of the Michigan no-fault statute that are at issue include section 3107 which states: "(1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following: (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." In addition section 3157 of the statute states.

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

MCLA 500.3157.

In their complaint, Plaintiffs claim that the actions of

the Defendant insurance and review companies are in clear violation of the no-fault act. They seek a declaratory judgment setting out various rights and responsibilities of the parties under the act, a preliminary injunction, and a permanent injunction. They allege claims of tortious interference with existing contractual relations, tortious interference with business relations, conspiracy to tortiously interfere with existing business and contractual relationships, common law fraud, and eight violations of RICO, 18 U.S.C. § 1962(b).

The Defendants put forward a number of grounds for dismissal under Rule 12(b). This Court will first address the 12(b)(6) motions with respect to the federal claims raised by the Plaintiffs. Because Plaintiffs' state claims raise issues of state insurance regulation which are inextricably involved with state law, this Court will remand this matter to state court if the counts raising federal questions are dismissed.

I.

In evaluating a motion to dismiss under Rule 12(b)(6), a court must construe the complaint in the light most favorable to the plaintiffs, accept all factual allegations as true, and determine whether the plaintiffs undoubtedly can prove no set of facts in support of their claim that would entitle them to relief. *Columbia Natural Resources, Inc. v. Tatum,* 58 F.3d 1101, 1109 (6th Cir. 1995), *cert. denied* _ U.S.__, 116 S.Ct. 1041, 134 L.Ed.2d 189 (1996).

II.

The Plaintiffs raise a number of alleged violations of

section §1962(b) of RICO. Section 1962(b) states "[i]t shall be unlawful for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce."

> To establish a violation of RICO cognizable in a civil action, the plaintiff: must allege the existence of seven coTzsfituent elements: (1) that the defendant (2) through the commission of two or more acts (3) constituting a "pattern" (4) of "racketeering activity" (5) directly or indirectly invests in, or maintains an interest in, or participates in (6) an "enterprise" (7) the activities of which affect interstate or foreign commerce.

United States v. District Council of Nesv York City, 778 F.Supp. 738, 751 (S.D.N.Y. 1991) (citing *Moss v. Morgan Stanley Inc.*, 719 F.2d 5, 17 (2d Cir. 1983), cert. denied, 465 U.S. 1025 (1984)).

The predicate acts alleged by the Plaintiffs in this matter are mail/wire fraud and extortion. The Plaintiffs contend that a number of acts on the part of the Defendants constitute fraud and/or extortion. They claim that since 1992, the Defendant insurance companies have used the Defendant review companies to review whether the products, services, and accommodations used by the health care providers were reasonably necessary and whether the billed costs were reasonable. The Plaintiffs claim that the Defendants used irrelevant data, such as worker's compensation fee schedules,

in reviewing the bills. The Plaintiffs also allege that the Defendants have interfered with their attempts to collect from their patients the amount the insurance companies refused to pay. This practice employed by the Plaintiffs is called "balance billing." The Plaintiffs complain that the insurance companies have stated that their insureds are not responsible for the balance, and the Defendants have allegedly sent letters to the patients and providers setting forth their position on this issue. In addition, they have threatened legal action against the providers if the Plaintiff health care providers attempt to balance bill the insured individuals.

"Mail fraud consists of 'a scheme or artiface to defraud and a mailing for the purpose of executing the scheme'.... A scheme to defraud consists of [i]ntentional fraud, consisting in deception intentionally practiced to induce another to part with property or surrender some legal right, and which accomplishes the designed end.'" *Kenty v. Bank One,* 92 F.3d 384, 389 (6th Cir. 1996)(quoting *Bender v. Southland Corp.*, 749 F.2d 1205, 1215-16 (6th Cir. 1984). The *Kenry* court also explained that "[t]o allege intentional fraud, there must be proof of misrepresentation or omissions which were "reasonably calculated to deceive persons of ordinary prudence and comprehension."' ... The plaintiff must also allege the facts showing the plaintiff's reliance on the defendant's false statement of fact [or omission].' *Id.* (quoting *Blount Fin, Servs., Inc. v. Walter E. Heller & Co.*, 819 F.2d 151, 153 (6th Cir. 1987).

"Extortion requires the obtaining of property through the wrongful use of threatened violence, force, or fear." *Whaley v. Auto Club. Ins. Ass'n,* 891 F.Supp. 1237, 1240 (E.D. Mich. 1995)(citations omitted).

With respect to the claims of fraud and extortion, a separate issue is whether the Defendants had the proper intent to conmait the alleged acts. Routine business communications that only demonstrate a dispute between the parties do not give a reasonable inference of fraudulent intent. *Atlantic Gypsum v. Lloyds Intern. Comp.*, 753 F.Supp. 505, 513 (S.D.N.Y. 1990). Different positions under a contract, even if one interpretation may constitute a breach, does not constitute fraud. *Blount*, 819 F.2d at 1.52 - 53. Also, a good faith dispute over the interpretation of a state statute does not constitute an intent to defraud. *Whaley*, 891 F.Supp. at 1240. Finally, "[t]he existence of a genuine dispute .... acts as a bar to RICO claims. *United National Bank v. Federal National Mortgage Ass'n*, 860 F.2d 847, 858 (8th Cir. 1988).

In this matter the Plaintiffs cite to Michigan case law and the no-fault statute and claim that (1) ii is clear that the Defendants do not have a right to stand in the way of their attempts to balance bill their patients; (2) the insurance companies may not defend their insureds without the consent of the insured individual; (3) health care providers are permitted to collect from their patients regardless of a determination by an insurance company that the cost or procedure was unreasonable; (4) the Defendants may not use fee schedules in determining the reasonableness of the health care providers' charges. The Plaintiffs conclude that the Defendants' interpretation of the no-fault statute is incorrect. Not only do they claim that the Defendants' interpretation is incorrect, they claim that the Defendants' actions based upon their alleged incorrect interpretation constitute fraud and/or extortion.

The Defendants rely upon Michigan case law, the no-

fault statute, and opinions of Michigan's attorney general and insurance commissioner. They claim that under Michigan law (1) insurance companies have a duty to check the reasonableness of the bills submitted by health care providers; (2) insurance companies have a cost policing function under the no-fault act; (3) if the bills submitted by the health care provider are unreasonable, the health care provider is not entitled to enforce the unreasonable contract; (4) if a fee which a health care provider seeks to collect is arguably within the scope of insurance coverage, the insurer has a duty to defend its insured, and (5) any dispute over the reasonableness of a bill is between a provider and insurance company, not the provider and insured.

After reviewing the complaint in a light most favorable to the Plaintiff, this Court finds that at best the Plaintiffs have set forth a valid issue as to the interpretation of the Michigan no-fault statute, not a pattern of racketeering activity. This appears to be a good faith dispute as to the rights, duties, and obligations of the key players involved with the Michigan no-fault statute. Even if a court adopts the Plaintiffs' interpretation of the insurance companies' duties under the no-fault act, there is nothing in the complaint, except numerous legal conclusion by the Plaintiffs, alleging that the Defendants had the intent necessary to sustain a claim of fraud or extortion. On a 12(b)(6) motion, this Court is not obligated to accept the legal conclusions stated by the Plaintiffs.

In addition, as to the fraud claims, the Complaint fails to allege the Plaintiffs' reliance on the alleged false statements by the Defendants. instead, the Complaint states that the health care providers refused to accept the insurance companies' conclusions regarding file providers' bills, See

Complaint, ¶168(e). With respect to the claims of extortion, the only coercion alleged by the Plaintiffs is the litigation threatened by the Defendants. This threatened litigation arose out of the Defendants' interpretation as to their duties under the insurance policy and no-fault statute. "A statement of intention to file suit to enforce one's claimed legal rights is neither a threat nor the exercise of unlawful or wrongful coercion." *Various Markets Inc. v. Chase Manhatten Inc.*, 908 F.Supp 459, 468 (E.D.Mich. 1995). As a result, the Plaintiffs have failed to allege a claim of fraud or extortion. Therefore, the Plaintiffs have failed to plead a predicate act upon which they can base a RICO claim.

In addition, this Court finds that the Plaintiffs have also failed to allege a RICO enterprise. The RICO statute explains that "enterprise includes any individual, partnership,corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." 18 U.S.C. § 1961(4). A RICO enterprise must also have an ascertainable structure separate and apart from the pattern of racketeering activity engaged in by the defendant. *Chang v. Chen*, 80 F.3d 1293, 1298 (9th Cir.1996)(citing *United States v. Turkette*, 452 U.S. 576, 583(1981)).

The enterprise alleged by the Plaintiffs is the association of individual insurance companies and review companies which assisted them. The Plaintiffs state: "It is clear they acted together. Otherwise, the review companies would have had no part in the processing of automobile no-fault related medical claims." (Plaintiffs' brief [docket # 88] at p.61). The "enterprise ... was created solely for the purpose of carrying out the fraudulent scheme complained of

by the Plaintiffs." (*Id.* at 64). "There is no other way in which review companies could have become involved in the processing and/or payment of automobile fault related medical claims except for such an association to have occurred." (*Id.* at 66).

This Court finds that the Plaintiffs have failed to allege an ascertainable structure separate from the alleged pattern of racketeering. The Plaintiffs merely claim that the alleged enterprise is synonymous with the alleged racketeering acts. This is not a sufficient claim of an ascertainable structure separate from the alleged enterprise.

The Plaintiffs rely on *Brownell v. State Farm Mul. Ins. Co.*, 757 F.Supp. 526 (E.D. Pa. 1991) for the proposition that the Defendant insurance and review companies combined to form a number of enterprises. However, the *Brownell* court did not even address whether the alleged enterprise was separate and apart from the pattern of activity in which it allegedly engaged. *Id.* at 539. As stated above, the Plaintiffs have not alleged an ascertainable structure separate from the alleged enterprise.

For the reasons stated above, this Court finds that the Plaintiffs have failed to allege a RICO claim under section 1962(b) sufficient to sustain a rule 12(b)(6) challenge by the Defendants. Because the Plaintiffs have failed to sufficiently allege the predicate acts or an enterprise, it is not necessary, to determine whether the Plaintiffs have sufficiently alleged that the Defendants acquired and maintained control of the enterprise through racketeering or that the Defendants' acquisition or control of the enterprise resulted in an injury to the Plaintiffs.

III.

The Plaintiffs' second federal claim is found in Count 3 of the Complaint. In Count 3, a request for permanent injunctive relief, the Plaintiffs state that,

> The efforts by the Defendant insurance companies [that they "are entitled to refuse to pay for some of the health care sevices provided to their insureds" and that their determinations are controlling]... are improper, and, because of the nexus between the insurance companies and the State of Michigan in implemeting the objectives of the No-Fault Act, said efforts constitute state action which, to the extent they have succeeded and are likely to continue to succeed to interfere with valid contracts between health care providers and their patients, will violate Article 1, §10 of the Michigan Constitution and the due process of law provisions of the Michigan and United States Constitutions.

(Plaintiff's Complaint ¶ 139).

Therefore, the Plaintiffs allege that the actions of the Defendants violate the due process provisions of the United States Constitution.

"The protections of the due process clause can only be invoked when there has been state action." *Shavers v. Attorney General*, 402 Mich. 554 (1978) *cert. denied*, 442

U.S. 934 (1979)(citing *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 349-350; 95 S.Ct. 449, 42 L.Ed.2d 477 (1974)).

The Plaintiffs claim that under *Shavers* and *Jackson*, the entire no-fault insurance regulatory scheme is subject to due process scrutiny. *Shavers* dealt with the denial of applications for no fault insurance. The court found that denial of coverage effectively prevented individuals from driving and that the mobility provided by an automobile is a crucial, practical necessity. *Shavers*, 402 Mich. at 598. It also noted that "[a] driver's license, once issued, is a significant interest subject to constitutional due process protections." *Id.* at 599 (citing *Bell v. Burson*, 402 US 535,539, 91 S.Ct. 1586, 29 L.Ed.2d 90 (1971)). The court stated,

> The No-Fault Act compels insurance for all motor vehicles; failure to comply with this requirement may result in criminal and civil sanctions. In addition, the No-Fault Act specifies the extent of coverage to be provided and the conditions of payment for insurance benefits. Finally, the No-Fault Act and the Imurance Code provide for the assignment of claims and risks. In effect, insurance companies are the instruments through which the Legislature carries out a scheme of general welfare. This legislation goes beyond a grant of a monopoly or an attempt to regulate a utility; there exists "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the

> (regulated entity) may fairly be treated as that of the State itself.

Id. at 597.

The Defendants contend that no essential right equivalent to the right to drive is implicated in th.is case. The Defendants also cite to the factors listed by the Supreme Court in the *Jackson* decision:

> The mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment. Nor does the fact that the regulation is extensive and detailed, as in the case of most public utilities, do so. It may well be that acts of a heavily regulated utility with at least something of a governmentally protected monopoly will more readily be found to be 'state' acts than will the acts of an entity lacking these characteristics. But the inquiry must be whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself. The true nature of the State's involvement may not be immediately obvious, and detailed inquiry may be required in order to determine whether the test is met.

Jackson 419 US at 350 - 51.

This Court finds that a dispute between insurance companies and health care providers over what is a reasonable charge and over whether a health care provider is permitted to balance bill under the no-fault act does not convert the insurance companies' actions into state action for due process purposes. *Shavers* should not be read to cause every action by a no-fault insurer to be state action for due process purposes. This case does not implicate issues which are similar to an individual's ability to get no-fault insurance, and consequently to drive. The Defendants' review of the reasonableness of bills and challenge to the health care providers' attempts to balance bill do not have a sufficiently close nexus to the state so that the Defendants' actions may be fairly treated as that of the state itself. Because the alleged actions of the Defendants do not constitute State action, the Plaintiffs cannot invoke the protection of the due process clause. Therefore, the Plaintiffs' due process claims must be dismissed.

The Plaintiffs' remaining claims are based upon state law. Because the only federal claims have been eliminated, comity compels this Court to decline to exercise supplemental jurisdiction over the remaining state law claims. See *Carnegie-Mellon v. Cohill,* 484 U.S. 343, 357, 108 S.Ct. 614, 622, 98 L.Ed.2d 720 (1988). Because the matter was removed from state court, this Court may exercise its discretion and remand the remaining state law matters to state court. *Id.* 484 U.S. at 351, 108 S.Ct. at 619, 98 L.Ed.2d 720. Therefore, the remaining state law claims shall be remanded to Eaton County Circuit Court.

An order consistent with this opinion shall be entered.

Dated: June 19, 1997

/s/_____
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed June 20, 1997]

Case No. 5:96-CV-177
HON. ROBERT HOLMES BELL

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation, et al., *Plaintiffs,*	)
v.	)
AUTO CLUB INSURANCE ASSOCIATION, a Michigan Corporation, et al., *Defendants.*	)

ORDER

In accordance with the opinion entered this date

IT IS HEREBY ORDERED that Counts 8 -15 of Plaintiffs' Complaint are **DISMISSED** for failure to state a claim upon which relief can be granted.

IT IS FURTHER ORDERED that Plaintiffs' Federal Due Process claims in Count 3 of the complaint are **DISMISSED** for failure to state a claim upon which relief can be granted.

IT IS FURHER ORDERED that Plaintiffs' remaining claims are **REMANDED** to Eaton County Circuit Court.

IT IS SO ORDERED.

Dated: June 19, 1997

/s/_____
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE